EXHIBIT V - Part 1

Bondi Deposition

Joseph Papin

vs.

University of Mississippi Medical

Deposition of:

Steven Bondi

February 03, 2021

Vol 1

PHIPPS REPORTING

Raising the Bar!

IN THE UNITED STATES DISTRICT COURT

FOR THE SOUTHERN DISTRICT OF MISSISSIPPI

JACKSON DIVISION

JOSEPH PAPIN,

Plaintiff,

VS. CASE NO.: 3:17-CV-763-CWR-FKB

UNIVERSITY OF MISSISSIPPI MEDICAL CENTER; DR. LOUANN WOODWARD, in her official capacity; and DR. T. MARK EARL, in his individual capacity,

Defendants.

DEPOSITION OF STEVEN BONDI, M.D.

STIPULATIONS

IT IS STIPULATED AND AGREED, by and between the parties, through their respective counsel, that the deposition of STEVEN BONDI, M.D. may be taken before Mellie Pierce, Commissioner, State of Mississippi at Large, at the offices of Brooks Court Reporting, 12 Lakeland Circle, Suite A, Jackson, Mississippi, Via Zoom on the 3rd day of February, 2021, commencing at or about 10:30 a.m.

BEFORE: Mellie Pierce, CCR #1933

APPEARING ON BEHALF OF THE PLAINTIFF VIA ZOOM:

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APPEARING ON BEHALF OF THE DEFENDANT VIA ZOOM:

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INDEX

EXAMINATION BY: PAGE NO.
Mr. Gregory Schmitz---------- 4 - 179

EXHIBITS

1 - Steven Bondi C.V.
2 - E-mail-Papin Complaints.pdf
3 - Eklund Case Records.pdf
4 - E-mail-Thread discussing hearing
5 - Appeals Protocol.pdf
6 - Notice Letter to Papin.pdf
7 - Email-Meeting with Bryce.pdf
8 - Bondi Notebook.pdf
9 - Appeals Hearing Transcript.pdf
10 - Mark Earl December 20th, 2016

*** MR. SCHMITZ RETAINED EXHIBITS. SHARED IN CHAT ROOM. NEVER MARKED. ***

STEVEN BONDI, M.D.,

having been first duly sworn remotely, was examined and testified as follows:

EXAMINATION BY MR. SCHMITZ:

Q. Good morning, Dr. Bondi.

A. Good morning.

Q. Could you, please, state your full name for the record.

A. Steven Bondi.

Q. And have you ever had your deposition taken before?

A. No.

Q. Okay. Well since you are an attorney, and I kind of assume you kind of know the drill, but, you know, just kind of keep it, you know, the yes or no questions, if you can. Huh-uh's and uh-huh's, you know, nodding your head or shaking, the court reporter can't pick that up. If you don't understand a question I ask, please, don't hesitate to ask me to rephrase it, I will be happy to do so. If you need a break at any time, that's fine with me just as long as we answer the question that I have pending, then we can take a break.

Have you ever testified at -- oh, wait, what is your current address?

A. 3991 St. Paul Boulevard, Rochester, New York 14617.
Q. Okay. And your date of birth?
A. April 28th, 1968.
Q. And have you ever testified or been part of any other kind of court proceedings, hearings, stuff like that?
A. Yes.
Q. Okay. What were those?
A. So I have testified before grand juries and in criminal juries in my role as a special agent for the Bureau of Investigation.
Q. Okay. And that's all, any other examples?
A. I believe that is correct. Yes.
Q. Have you ever been convicted or charged with any crimes?
A. No.
Q. And I have to ask this, but are you under the influence of any drugs of any kind, or do you have any medical conditions which may prevent you from accurately and truthfully answering my questions here today?
A. No.
Q. All right. And so today when I share the exhibits, if you click the chat button, I'll be popping the PDS into the chat and you can just open it and we

can all follow along together. Okay?
A. Okay.
Q. Dr. Bondi, take a look at Exhibit 1, do you recognize this?
A. Sorry, it wasn't opening. It just did. Yes.
Q. Okay. Is this your resume or CV?
A. Yes. It is a version of it. It is one of them. Yes.
Q. Sure. Sure. I don't know when this was up-to-date, but this is what we were just able to find online. Does it look like it -- Exhibit 1, truly and accurately reflects your professional background?
A. Just give me a second to look it over, please.
Q. Yeah. No problem. No problem. Just as in aside, you're at the University Rochester Medical Center?
A. That is correct.
Q. Do you know a Dr. Page, P-A-I-G-E, in the neuroscience?
A. I do not.
Q. Okay.
A. You know, I think this is pulled off of various information from LinkedIn or maybe another data -- another resource. But the information contained on there is accurate. I did not put the industry knowledge

stuff in there.

Q. Okay.

A. So that may have come from somewhere else.

Q. No problem.

A. It's missing information.

Q. Okay. What would it be missing?

A. For one, it's missing my Mississippi Medical License, which now is -- has expired. It's missing my Massachusetts legal license. It's missing my board certification in general pediatrics.

Q. Okay.

A. My Army role is not as -- I mean I was on active duty for six years. And then have been in the National Guard since then. So that's not exactly correct. But in terms of my appointment at the University of Mississippi, that is correct. And I'm now -- yeah, so that's -- that's fine.

Q. No problem. No problem. Okay.

MR. SCHMITZ: And, Tommy, for ease of reference, would you mind, if I -- or would you have any objections if I had Exhibit 1 admitted for demonstrative purposes?

MR. WHITFIELD: No. No objection.

Q. (BY MR. SCHMITZ) Okay. So you went educational background wise, you went to William & Mary

and you got a -- was it double major in computer science and history?

A. That's correct.

Q. And then you attended right after that Harvard Law School?

A. Yes.

Q. And then you were at the University of Rochester, and you have your MD in dentistry?

A. No.

Q. Or MD in medicine, or how does that go?

A. I have a Doctor of Medicine from the University of Rochester School of Medicine and Dentistry.

Q. Okay. And then you did a -- your residency was at Madigan Army Medical Center?

A. That is correct in pediatrics.

Q. In pediatrics. Okay. Is that a ACGME Accredited program?

A. Yes.

Q. And then your fellowship was at Vanderbilt?

A. Yes.

Q. So it looks like right after law school you were a federal law clerk?

A. I was.

Q. With the U.S. District Court, Rhode Island.

Okay. It looks like a one-year appointment; correct?
A. Yes.
Q. And after that, Shipman & Goodwin, is that a national firm, a large firm?
A. At the time, it was about a 100 lawyer firm exclusive. I believe exclusive offices in Connecticut. There may have been an office in Florida -- a tiny office in Florida. Some of the Connecticut law firms, I don't recall.
Q. What type of law did you practice?
A. I was -- did general corporate litigation. Did as most people in Hartford do insurance work, but it was insurance focused. It's surety law litigation. Did some health care law litigation as well.
Q. Okay. And so your background in health care law litigation, is that what sort of led you to your position as the eventually down the road many years later into the Medical Director, Risk Management at UMMC role?
A. I certainly think that it informed that. I was also interested in the overlap between law and medicine.
Q. And FBI Special Agent from May 1996 to August 1999. What type of things did you do at the FBI?
A. I was -- my primary focus was intellectual

property and computer crime.

Q. Okay.

A. So we dealt with copyright trademark and corporate espionage, as well as various computer crimes, mostly like hacking and things like that.

Q. And in the FBI, I'm assuming during your training, you learned to interrogate and question witnesses?

A. Sure. Yeah. I interview, interrogate, question. Yes.

Q. Okay. Then sort of after 1999, just by this -- so you were in the U.S. Army for a while after that, is that what that was?

A. In 19 -- 2001 after --- during my first year of medical school here Rochester.

Q. Okay.

A. I joined what's called the United States Army Health Professional Scholarship Program, which is a -- it has the military pay for your medical education. In my case, three of my four years of medical education in exchange for payback on active duty at the end of medical school on train. And so that was 2001. And then I went on active duty in 2004 after I graduated from medical school, the first three years of that time was in pediatrics residency, which we discussed at

Madigan Army Medical Center, and that was followed by a three-year active duty such as an attending physician in the Army.

At the end of my active duty obligation in 2010, I left the active duty to go into fellowship and pediatric critical care. And during that time into the present, I have served in the United States Army National Guard.

Q. And after your fellowship, and you went into it says Assistant Professor of Pediatrics at UMMC as well as the -- your role -- well I guess one year after that, then you were kind of giving a dual role with the Medical Director, Risk Management at UMMC?

A. Yes. When I started, I started as the Assistant Medical Director for Risk Management at UMMC, and then about a year later, I transitioned into being the Medical Director.

Q. And what types of background did you have as a, you know, that led you to your role as the Risk Manager at UMMC?

A. Can you restate that a little bit?

Q. Sure. What in your background got you into risk management at UMMC?

A. Well I have an interest because of my -- because of my legal background. And I was looking for an opportunity to blend those two skill sets. Pretty much anybody who serves in an academic medical center has a job as a clinician, which means taking care of patients. In my circumstance, Pediatric Critical Care.

But every faculty member also has an academic role or an administrative role. And so I was -- my -- my goal was to develop that role in law and medicine. And part of that was the administrative role, which was getting involved in the risk management space. So it was both a desire I believe that when I started that role working with individuals, I showed aptitude hence my advancement from Assistant Medical Director to Medical Director.

Q. All right. During your time as working in pediatric at UMMC, you worked with Dr. Barr; correct?

A. At the -- for most of my time at the University of Mississippi Medical Center, Dr. Barr was the Chair of the Department of Pediatrics. Yes.

Q. Okay. So you would interact with him regularly, I'm assuming he would be the head of the meetings and everything, department meetings and all that?

A. Yes.

Q. Okay. Did you directly report to Dr. Barr?

A. No. It's kind of complicated in academic medicine. But I mean he was my bosses boss. I think that all faculty members in the Department of Pediatrics ultimately answer to the Chair of the Department of Pediatrics. But my direct boss was the Division Chief for Pediatric Critical Care. And that was a physician --

Q. And who is that?

A. -- named Mary Taylor.

Q. Okay.

A. And Mary I believe now is the Chair of the Department of Pediatrics, if my information is correct.

Q. When did that transition happen from Dr. Barr to Mary?

A. Oh, Dr. Barr left right about the time that I did. I don't know if he left right before I did. And I believe that she -- I don't know the specific dates. But it was -- it was right there in the summer or fall of 2017.

Q. And when you left UMMC in the summer or fall of 2017, where did you go next?

A. To the University of Rochester.

Q. Okay. Prior to your deposition here today, did you review any documents in preparation for this deposition?

A. Yes.

Q. Which documents did you review?

A. Mr. Whitfield had provided me with a variety of documents; specifically, it included the transcript of the hearing.

Q. Okay.

A. That I -- that I -- the hearing that I took. It had some of my, like my -- I assume, I don't know how many of them, but my e-mails because I didn't have access to those e-mails anymore. Those were provided to me. There was photocopies of a notebook that I had in my role in risk management, I would -- and other roles that I had in the institution, I kept -- I kept notes. There was -- I believe there was also a copy of the human resources' transcript that Dr. -- the interaction that Dr. Papin had. And I -- there were some other documents as well pertaining to some policies and surrounding residents or I should say employee combination, things like that. I think that -- I think that covers everything.

Q. Okay. And, obviously, I don't want to know the substance of your conversation, but did you meet with Tommy to discuss today's deposition prior to today?

A. Yes.

Q. Okay. When did you meet with Tommy?

A. We had an extensive conversation on Monday.

We had a very brief conversation yesterday, it's probably a little less than five minutes, maybe ten minutes.

Q. Okay.

A. We also had had a similar conversation prior to the original date of this deposition, so what was that, eight weeks ago? I don't remember the precise date. But he and I had had a -- had had a conversation an hour, maybe an hour-and-a-half prior to that initial -- initial meeting or the initial planned deposition. I'm sorry.

Q. Sure.

A. And then he and I had had some earlier conversations, we had just kind about the general aspects of the lawsuit. Not the substance procedure. Over the last two years I guess.

Q. Okay. And so multiple kind of conversations regarding the lawsuit over the last two years, and then leading up today, there was a conversation about two months ago or so?

A. Yes.

Q. And then you said you met with him on Monday, how long did you meet with him on Monday?

A. I little bit less than 90 minutes I believe.

Q. Okay. Do you recall in Dr. Papin's appeal

there was an issue brought up regarding a patient who had a decubitus ulcer, do you recall that?
A. Yes.
Q. Okay. And, you know, it was alleged that Dr. Papin was not being truthful regarding his treatment of that patient during the hearing?
A. That was one of the issues that was a part of the hearing. Yes.
Q. The patient's name was Mr. [redacted], does that ring a bell?
A. No. I don't -- I don't recall knowing the name of the patient. I may be mistaken. It may have come up in the hearing. I certainly didn't know anything before the hearing.
Q. Okay. Did you ever review the patient's medical chart or records prior to Dr. Joey Papin's Appeal Hearing?
A. No.
Q. How many times have you been involved in hearings, involving the termination of UMMC faculty?
MR. WHITFIELD: Object to the form.
Q. (BY MR. SCHMITZ) Go ahead and answer.
A. What do you mean by "involved?"
Q. As either part of the panel or being a chair of the hearing?

A. Okay. I was in -- I was involved in another case involving a faculty member, but a hearing was never held.

Q. Was that Dr. Eklund?

A. Yes.

Q. So Dr. Papin was the first time you were ever part of a panel or chaired panel on a resident termination?

A. Yes.

Q. And your only other involvement prior to that was with Dr. Eklund?

A. Yes. The only time I've been asked to serve or anticipated serving in a -- as a hearing officer or as a member of a panel was with Dr. Eklund, the only other time.

Q. Do you believe as a lawyer, that an accused ability to confront and cross-examine witnesses is essential to discovering truth?

MR. WHITFIELD: Object to the form.

THE WITNESS: I think it depends upon the venue, the circumstance. I -- I -- I think that question is far too broad for me to answer.

Q. (BY MR. SCHMITZ) In what ways, how so?

A. Because there are multiple ways of gathering the truth. There are multiple venues for that to happen. There are administrative hearings. There are civil court proceedings, there are criminal court proceedings, and all of those have different procedures and processes.

Q. But wouldn't you agree as a lawyer and an FBI investigator, that having the ability to cross-examine witnesses would be something that's important in getting facts out of witnesses, which might not otherwise be reflected in other types of evidence?

A. I think it can be done --

MR. WHITFIELD: Object to the form. Go ahead.

THE WITNESS: I said I think it can be done in a variety of ways. I think the implication that I do not agree with, is that it is a necessary condition to have cross-examination to elicit the truth. I do not agree with that statement.

Q. (BY MR. SCHMITZ) Do you believe as a lawyer, that having one side with a trained lawyer and the other side's lawyer not being able to ask questions of witnesses complies with due process in the administrative hearing role that you conducted in Dr. Papin's hearing?

A. I do not agree with that statement.

Q. Where did you learn the format that you used

at Dr. Papin's appeal hearing?

A. There was a meeting with counsel where we discussed --

MR. WHITFIELD: And I'm going to object to what was discussed at his meeting with counsel.

Q. (BY MR. SCHMITZ) Okay. So he's saying you can talk about how you learned about that without exactly discussing the substance of your conversation with counsel, please, do.

A. I'm going need some help with that.

Q. Are there certain policies or guidelines that you were following that you can discuss regarding the format of Dr. Papin's hearing?

A. In the process preparing, I looked at the ACGME requirements, which really I shouldn't even call "requirements," there's really not a lot of guidance there. And so in the absence of anything specific, that's when I had a conversation with counsel.

Q. What do the ACGME requirements state for --

A. I don't recall off the top of my head. I'd have to refresh my recollection.

Q. Is there anything specifically that you recall?

A. It wasn't anything -- it wasn't anything very helpful.

Q. In terms of -- I mean as a lawyer, I'm just going to hit you with this question because you are a trained legal professional, in terms of substantive and procedural due process, you are familiar with those terms?

A. Of course.

Q. Okay. And I guess we'll start off with the first one. In what ways as the chairperson over Dr. Papin's hearing, did Dr. Papin, at least in your opinion, was he provided with procedural due process?

A. I don't --

MR. WHITFIELD: Object to the form. You can answer the best as you can.

THE WITNESS: Yeah. I don't think at this point, I can differentiate sufficiently between substantive and procedural due process to answer that question.

Q. (BY MR. SCHMITZ) Okay. Well what ways was Dr. Papin -- in what ways did Dr. Papin receive due process to the extent that you under -- based on your understanding of what that means?

A. Okay. With regards to our hearing, he received notice that the hearing was going to occur. He received notice of what the substance of the hearing was going to be. He heard what the witnesses had to say.

And he had the opportunity to rebut what those witnesses had to say. And he had the opportunity to present evidence on his own behalf.

Q. Did -- in talking about receiving notice of what things were going to be brought against him, do you know if Dr. Papin ever received a copy of the medical records for any of the alleged patient care issues that were brought up at the hearing?

A. I have no idea.

Q. Don't you think that would be something that's important for a hearing regarding allege -- be based on allegedly being a danger to patients for them to be able to look at the records to rebut any instances where they may have deviated from the standard of medical care?

A. I think the individuals that were involved, were testifying firsthand, which Dr. Papin was able to hear. And he was able to present from his perspective, his view of the events as well.

Q. And but you did not allow -- Dr. Papin had counsel present there; correct?

A. Yes.

Q. And Dr. Papin was attending the hearing remotely?

A. Yes.

Q. And his counsel was attending remotely;

correct?

A. No. His counsel was in the room.

Q. But his counsel was not allowed to ask any questions?

A. His counsel was not allowed to ask any questions of the witnesses. Neither was counsel for the University or outside -- both internal and external counsel who were also present there.

Q. Was Dr. Papin allowed to directly ask questions of the witnesses, or were those filtered through you?

A. They were filtered through the committee. He was allowed to present his information, and the committee members asked questions based on what he -- the issues that he raised.

Q. Is it your opinion, that the format you used as the chair of Dr. Papin's appeal hearing, that it was fair and complied with all measures of due process?

A. Yes.

Q. Have you used that format before at the other UMMC hearing that you were a part of?

A. I've never -- I've never been involved in another actual hearing at UMMC.

Q. Are you aware whether the same format that you used during Dr. Papin's hearing was determined -- which

was determined to be unfair and sanctioned by the IHL in another hearing involving Dr. Eklund, was the same format you used?

A. I don't understand the question the way you're stating it.

Q. The same format that was sanctioned by IHL as being unfair and not complying with due process around the same time as Dr. Papin's hearing, is that the same format you used with Dr. Papin?

MR. WHITFIELD: Object to the form.

THE WITNESS: Once, again, I didn't -- I didn't have -- hold another hearing.

Q. (BY MR. SCHMITZ) I understand that.

A. The only hearing -- the only hearing I've ever presided over or been a part of when the hearing was actually held was Dr. Papin's.

Q. Right. But you were -- you were part of Dr. Eklund's hearing, and that hearing did not occur because I know that there was various legal issues, there was temporary injunction filed and -- and -- and whatnot, and there was a review, do you recall the review by the IHL Board determining that the hearing format that was being used for Dr. Eklund was -- did not comply with due process measures?

A. I was not part of the -- I was not part of the process during that part of Dr. Eklund's case.

Q. Sitting here today, if you became aware that certain parts of the evidence, which was presented at Dr. Papin's hearing was untrue or that witnesses were lying about certain things, could that potentially change your opinion on Dr. Papin's termination?

MR. WHITFIELD: Object to the form.

THE WITNESS: I mean there was a lot of evidence about many many many different incidents. And there was a lot of information provided about six months of Dr. Papin's work at the University of Mississippi Medical Center. So one specific piece of information or even two or three specific pieces of information that cast doubt in of themselves, probably not.

But to truthfully answer your question, yes. If absolutely everything was determined to be false or different than we reviewed, then, yes, I think that would raise that issue.

Q. (BY MR. SCHMITZ) And as a -- as a, you know, as a Director of Risk Management at UMMC, you're talking -- or when something comes upon your desk, an incident that takes place at UMMC; for instance, you conduct investigations into those incidents; correct?

A. Sure. Using the word "investigation" broadly.

Q. And during the course of -- and just again,

speaking broadly -- during the course of those investigations, you review the underlying documents that are presented to you, and do you go speak with witnesses and people to get firsthand account of what may have taken place?

A. Depending upon what happened, yes, either me or one of the individuals that was working for me. Yes.

Q. Other than what was presented to you in document form by Dr. Earl prior to Dr. Papin's hearing, did you conduct any investigation into any of the allegations that Dr. Earl had brought forth to you to determine their voracity?

A. I was never asked to investigate anything or examine or to look into anything regarding Dr. Papin. And I will give one caveat to that, in the course of the e-mails that were provided to me to review, there is an e-mail that I sent to Dr. Earl, which I assume was in response to a query that he had asked me to see whether there was anything that risk management had known about Dr. Papin. With the exception of that, there -- there wasn't anything.

Q. Was there anything that risk management had been aware of Dr. Papin?

A. No. Not based on the day-to-day search that was done by Darlene Bryant who is the Director of Risk

Management who kind of worked with me for me, she was the day-to-day operations person, so she queried both the event reporting data base, as well as the -- as well as the patient complaint data base to see if Dr. Papin's name appeared there. There is a caveat to that though, in that the event reporting data base is really focused on the patient, not necessarily on the provider. So frequently events that go into that data base, don't have any physician associated with that. Or I shouldn't say "physician," any employee associated with that.

Q. At UMMC, what typically triggers the involvement of risk management in a case, like, is it when an iCARE report or some type of incident variance report is filed?

A. Yeah. That's a good question. So there are really probably two -- I shouldn't say "probably." There are two primary ways we find -- we'd find out about a case. One is by the use of the iCARE system, which is what UMMC calls its event reporting system. All hospitals are required by CMS to have an event reporting system. That those -- that's a broad net system. Any employee can go and put it -- and report an event. And they are -- the coverage of this system is very very broad. It could be, you know, appeared to be a slick sidewalk that wasn't attended to. It could be, you know, it could be any number of things. So that would be one way.

Typically, the other main way would be a direct communication with my office. The Director would get -- would often get phone calls. The individuals that worked for her, our nurse coordinators, also had general areas of a hospital that they would be assigned to. And so an individual in that area of the hospital, it might be a department, it might be a nursing unit, it might call one of those coordinators directly, and that would filter its way up.

Those are the two main ways. Probably, the third main way would be through a -- either a patient complaint or grievance, or frankly, very very rarely a lawsuit. Almost everything that we had a malpractice lawsuit on, we knew in advance. But it -- but it wasn't -- but it did happen.

Q. Are you aware of any incidents where Dr. Papin, any of the patients he saw or cared for during his time at UMMC, whether there were any patient complaints or iCARE reports filed regarding his care of any patients?

A. I don't have -- I don't recall any based on that e-mail of -- of -- that I sent to Dr. Earl. As of January, there weren't any. Please, understand, that I left the Institution at the end of July of 19 -- of 2000 -- sorry, of 2017. So something could have happened after that, but I, you know, 'cause sometimes there's a lag.

Q. You left immediately after basically -- because I believe his appeal hearing was in July of 2017, so you left basically right after you were done with his hearing?

A. Correct. Well I mean it was several weeks later, and it wasn't abrupt. I had -- everybody knew I was changing jobs.

Q. Sure. When a complaint about patient care; for instance, an iCARE report or one of the other methods that you would receive a complaint regarding patient care specifically came in to risk management, what was the process that risk management would do to investigate those complaints?

A. It would depend greatly on the nature of the complaint. The vast majority of reports that came through our reporting system, would be handled at the unit level. Most of the iCARE reports that came in, dealt with -- I won't say every day -- but dealt with kind of the routine things that would happen on the patient care floors. So a medication being delivered late, a, you know, would be a very common one. You know, a lab sample that was delayed. So those things would typically be dealt by the nurse manager in that space. So most of the iCARE reports came were nursing unit centered, so a given floor of the hospital; for example.

Q. What about a more serious complaint in terms of something happening where, you know, care -- allegedly deficient care was rendered to a patient requiring some type of surgical intervention or remedy, what type of investigation would take part and take place in that?

A. So all of our three nurse coordinators who worked for Darlene Bryant, they would review this -- the iCARE reports as they came in. I won't say in real-time because nobody was on in the middle of the night. But probably for 12 or 14 hours a day, those would be reviewed. So there was a constant process of those being reviewed.

They would be bubbled up through Darlene and to me in terms of the severity of those. And then, typically, the coordinator would do kind of the first level review of them. Obviously, it depends upon the seriousness of the -- of the issue. And they would do chart review. They may talk to individuals, the front line individuals that were involved.

But my direct involvement in individual cases in terms of the investigation was uncommon. It was really -- it was maybe one a month. Maybe every other month in terms of my getting in the trenches and going and interviewing people. Occasionally, if a case did involve, especially, attending physicians, they'd ask me to talk to them just because the feeling would be that a physician to physician conversation is different than a nurse because the other individual's nurses.

But by in large, it was the nurse coordinators and Darlene Bryant as the Director who did the vast, vast majority of the evaluations.

Q. So earlier when we were discussing the decubitus ulcer patient that was brought up in Dr. Papin's hearing, are you aware why no incident reports or variance reports were -- or iCARE reports, any type of reports were ever filed regarding that patient?

A. I have no idea why something didn't happen.

Q. Okay.

A. It's -- first of all, that reporting is nationwide. Pick any hospital, is drast -- events are drastically underreported. There's actually a whole field of study within quality and patient safety on how to improve event reporting, and it's something that you have -- really have to work on it. It was something

that we were working on while I was at UMMC.
The second thing is, is that certain types of things are more likely to get reported than others. Frankly, I can tell you in my entire time with risk management there, in terms of decubitus ulcers that got up to the level of my being involved in them, I remember one -- one situation the entire time I was there regarding a decubitus ulcer. They're very common -- they're, unfortunately, a common occurrence in hospitals, and it's something that you have to be aggressive in terms of decreasing your rate of decubitus ulcers.
Q. And those are -- decubitus ulcers, that's a pressure ulcer usually, it's a bed sore essentially; right?
A. Laymen's terms, exactly right, it's a bed sore.
Q. Okay. And usually to treat bed sores, it's rotating the patient; correct?
A. Well the prevent -- I would say the preventative measure is appropriate positioning. There also are devices that can be used to reduce the rate of them, whether those are special mattresses or they are devices that you can put under a, you know, a point, a pressure point.

Q. Sure.
A. But, please, I'm not an experts in decubitus ulcers.
Q. Yeah. I would imagine you don't deal with it so much in pediatrics.
A. Oh, we deal with them a lot.
Q. Oh really.
A. Because I'm a pediatric ICU doctor. And so the risk is immo -- the biggest risk is immobility. And so patients in the ICU frequently are immobile because of the nature of their injuries or because we need to heavily sedate them because of -- because of the treatment.
So I certainly know about how to prevent them. Treatment kind of falls, what you do once the patient develops them, falls out of my purview. I mean I know generally. But the older more immobile adults certainly get them at a much higher rate than children. Children have much healthier skin too.
Q. You said typically that falls outside of your purview because you're the physician, usually, that's something the nurses have to keep up with; correct?
A. Yeah. Yeah. UMMC certainly had this. My current institution has this, a fairly aggressive wound care team. And so that's a nurse led team with

directors of usually by the plastic surgery department. So it's kind of a multi-tiered approach. That's like nurses are certainly instructed in wound care, and they're the ones who carry out certainly the preventive strategies. And then they work with the wound care nurses, the wound care team for treatment. And then the next tier is at extreme ends on that will involve surgical support. Sometimes general surgery, a lot of times plastic surgery.

But I believe that most of the wound care initiative in terms of the physician leadership at UMMC was plastic surgery.

Q. You said that there was another patient that where the decubitus ulcer rose to your level to where you had gotten involved, can you -- without giving the patient's name or anything -- can you describe what that situation was and what --

A. It was an eld -- it was a nursing home patient that was admitted. I think it was in my fist year. It involved a large decubitus ulcer. I believe that it had been in place from the nursing home when the patient came in. And it was actually very very early in my risk management tenure. I think it was actually when I was brand-new. So I don't remember any of the details, but I do have a distinct memory of it because it was actually -- it was actually my first interaction with the Chief of Staff of the hospital, who is still the Chief of Staff in plastic surgery. Which has nothing to do with Dr. Papin's case, but I do remember -- remember that interaction.

Q. In Dr. Papin's case, did you find it odd that the decubitus ulcer had not ever been reported to risk management for further investigation?

A. No.

Q. Why?

A. Decubitus ulcers are common and they're -- they are -- they are dealt with typically at the nursing unit level.

Q. Okay. And as the Chairperson in Dr. Papin's appeal hearing, have you -- and also the Director of Risk Management, had you wanted to investigate the decubitus ulcer that was brought up during Dr. Papin's appeal hearing to look over that patient's medical records, would you have had access to those records?

A. Oh, yes.

Q. Okay. But you did not review those records?

A. I did not. I did not review any patient care records in -- of any kind, to the best of my recollection, in Dr. Papin's case.

Q. Do you think it complies with due process for

Dr. Papin to not be given access to those records either so that he can rebut the allegations that were being brought against him at the appeal hearing?

MR. WHITFIELD: Object to the form.

THE WITNESS: As I said before, I think there was opportunity here from the witnesses. I think that Dr. Papin actually presented quite eloquently his view of what happened. And there's transcripts certainly that reflects that.

Q. (BY MR. SCHMITZ) In treating a patient in the residency context right, a resident is never just treating a patient by themselves; correct, they're overseen by an attending physician?

A. Yes.

Q. Okay. And that -- that is in all cases; right?

A. There are situations where there are residents who may be acting independently; for example, sometimes residents are working as that have a medical license will work in the emergency department that have -- where they have independence. That's not what was going on with Dr. Papin as an intern.

Q. Right.

A. So I can't -- you said "always," so the answer to that is no.

Q. Right.

A. But within the caveat that I said that certainly Dr. Papin as an intern would have been supervised in everything that he did.

Q. In his care of the decubitus ulcer patient that was in the hospital, he would have been overseen by an attending physician?

A. Yeah. There would have been oversight of what he did. But that doesn't mean that that attending physician saw everything, heard everything, nor could they have possibly done that in this case. But, yes, there was a supervising physician for him, as there was for all his patients, a supervising attending physician.

Q. So in investigating complaints regarding deficient patient care, would someone in risk management whether that be you or those attending nurses, they investigate or review a patient's hospital charts and medical records; correct?

A. Yes. That's where it usually starts.

Q. And how would you have access to the records, that's just all on your computer in your office in your desk when you were at UMMC?

A. Yeah. The vast majority of our records were contained within Epic, which is our electronic medical record system at UOR. There are other data bases that you might use the radiology stuff, but the images, x-rays, those might be in a different place. But, yes, I had access to all that stuff on my desktop as, you know, everybody does, that you can sit down at any workstation in the hospital, log in, and have access to those.

Q. And is it your understanding, that Dr. Papin, he was terminated for being a danger to patients, that was the reasoning given?

A. I don't remember the -- I don't remember the specific wording of it. But it was for a -- there were a multiple of factors involved.

Q. In your mind then, what were those factors that caused you to uphold his termination?

A. Well, you know, I'd have to look at, you know, I'd have to look at the exact wording of the letter. But there were many factors. Mostly, from our perspective, were focused on professionalism and honesty, those were -- those were the biggest factors.

Q. Speaking about professionalism first, what specifically regarding Dr. Papin's professionalism?

A. Interaction with peers. Interaction with students. Interaction with nursing staff. Those were -- those were high on the list for professionalism.

Q. Do you recall whether the interactions of

professionalism issues, were those presented to you by firsthand accounts by the people who experienced them, or were they mostly by secondhand accounts of people, you know, sort of through the grapevine that they heard that Dr. Papin did this or that?

A. So there -- there was both. There was the information that was firsthand provided by the individuals who testified at the hearing. There was also the information that was provided by Dr. Earl that he had gathered. And then there was also the written evaluations of Dr. Papin, so it was all of those sources.

Q. And you raise the issue of Dr. Papin, you had concerns regarding his candor and truthfulness, what was the basis for your suspicions about his candor and truthfulness?

A. I think it had to do with that same body of material, individuals and materials. Had to do with his presentation of rounds. Had to do with in some of the -- if I recall correctly -- some of the evaluations as well.

Q. So him whether or not he was actually doing his rounds as he said he was doing, that was one concern?

A. Yes.

Q. And that concern was whether he was actually seeing these patients to evaluate them and properly treat them?

A. Yes.

Q. What was the second one that you said? Sorry.

A. I believe there were some issues that were raised in his -- in his evaluate -- written evaluations, but I'd have to double check those.

Q. Do any come to mind that the types of specifically what those issues were?

A. I'd have -- I'd have to look back at those.

Q. So what were your job duties as UMMC's Medical Director of Risk Management?

A. So the duties were broad. And that title doesn't really do a good job of capturing everything that I did. I think I would start with saying that I was a member of the Chief Medical Officers Leadership Team, that was comprised of the Chief Medical Officer, Chief Safety Officer, myself, and the Chief of Staff of the hospital.

My specific, you know, kind of my niche, dealt with looking at events and issues that presented an overall risk to the institution. There is a certain amount of overlap with the quality and safety presence in a hospital. Often times we were the, you know, the risk management folks were the folks that identified the issues and then worked with the safety presence on bigger issues to solve them. I think that the categorization of it is risk management, it's not really the same as like a corporate risk management for a different kind of an institution. There's a lot of safety work and quality work that happens. So, you know, you might have a near miss with a patient that, you know, the pharmacy sent out the wrong medication, and the nurse caught it, and we're like well why did it get that far. How do we -- so we would look at the situation and kind of un -- you know, work our way backward and to try to fix that from happening in the future.

Sometimes things happened that got to a patient or an employee, and we'd say what do we do to fix that. So it's a lot of problem solving and troubleshooting. So that was probably a third or a half of what I did. A big piece of what I did, is I worked with the Universities Counsels Office on the cases that were in either active litigation or cases that were thought to lead to litigation. And I would assist the counsels office in analyzing as in those cases and make a determination on what a recommendation would be in terms of settling those cases or not settling those cases.

We had a Risk Management Committee that specifically answered those -- that provided advice on that. And then I worked with -- took that to the next step on the University -- on the counsels office. We would frequently talk -- I would frequently at the counsels office on not just whether to settle, but how much to settle the cases for.

I was the primary point contact to the Institution of Higher Learning on behalf of the Vice Chancellor and the General Counsel of the -- at the Medical Center presenting the cases for approval for settlement and answering those questions.

So that really encompasses the risk role. And then I did a lot of other things that were kind of under the chief's medical office, maybe on this penumbra of risks. I was the Chairman of the Grievance Committee, so patient complaints that came in, we lifted -- I help facilitate our patient affairs office in responding to those. They handled the vast majority of them, some of them rose to a higher level, and I assisted them.

MR. SCHMITZ: Dr. Papin, if you could mute your microphone, please. Sorry about that.

THE WITNESS: No problem. So -- so -- and then I -- we gathered statistics based on the patient, based on those patient complaints of grievance (inaudible) that is required to do by a CNS.

I participated in -- but I also participated, I sometimes help the medical staff office with some of the things that they were dealing with; that's involving physician credentialing. Also, kind of the ongoing -- kind of the, what would you call it, the not specific peer review because of a bad event necessarily, but also kind of our ongoing clerical confidence issues with the medical staff office.

So there was kind of this, a little bit of an overlap in the various roles that all of us had when we worked with each other.

Q. (BY MR. SCHMITZ) So do -- in terms of Dr. Papin's case, in anything that was brought to your attention during your course of looking into the alleged reasons for his termination, raise any legal specific -- legal related concerns from an exposure standpoint to UMMC?

MR. WHITFIELD: I'm going to object to the form. You can answer if you can.

THE WITNESS: I'm having to think about -- I have --

Q. (BY MR. SCHMITZ) Just the decubitus ulcer patient, the guy, you know, having the ulcer, would that

be something that you would have been concerned about enough to, you know, be following as one of those cases as potentially going to be a lawsuit, if had that report come to you in like the iCARE format or something like that?

A. Probably not from a decubitus ulcer. Like I said, there was that one -- there was that one case, but that was, if I recall, was already the substance of a lawsuit.

Q. Okay.

A. So, typically, I -- typically, we would not get -- the risk management stuff wouldn't get to my level based on no -- as you well know, there are lots of things you could be concerned about in any setting, particularly healthcare setting that potentially could give rise to a lawsuit. It's, you know, it's a variety of factors that makes them bubble up -- bubble up to the higher level.

Q. In decubitus ulcers, like you said, they're so common, sometimes they're inevitable; correct?

A. It depends upon how you look at it. I think that there are people in the patient safety world that would say that you should never have a decubitus ulcer. I -- I -- but I don't think anybody that works in the practical world would say that you can completely eliminate one. By aggressive -- aggressive work, you can drastically limit them.

Q. If a patient refuses to be turned or to be moved to an appropriate position to relieve pressure, would that be something that would make a decubitus ulcer unavoidable?

A. Or make -- certainly, make it more likely. Yeah. And sometimes we have patients that are so seriously ill, that even moving them a little bit is a challenge. We have some strategies that help to try to mitigate that, but you can't -- you can't drive that down to zero likely though.

What I would say, is that a decubitus ulcer is not a -- it's not a dichotomous state, it's not that you have one or you don't have one. There's stages of decubitus ulcers and close surveillance identification can have a drastic affect on being able to keeping an ulcer in a lower stage and let it heal. When they get to the higher stages, are what we call "unstageable," which is really like in many of circumstances, the worse stage, which is I guess kind of ironic.

But the goal often is to catch them early and mitigate them, so that they don't get worse.

Q. As the Medical Director of Risk Management, who did you report to?

A. My direct report in that role would have been Michael -- at the time for three quarters of -- for my second, third, and fourth year at UMMC, would have been Michael Henderson who was the Chief Medical Officer. I also reported to the office. It was the person changed -- changed after my first year.

Q. And what determined whether a complaint came to risk management or whether it would go to the office of public affairs?

A. I don't know -- I've never heard of the term the "office of public affairs." You talking about the patient affairs?

Q. Sure.

A. So patient affairs is for patient complaints. So if an individual -- an individual was upset about the amount of time they had to wait in the emergency room, is a very common complaint. That would come through our -- would come through to patient affairs. There was a widely publicized access points to them, phone numbers, websites, you know, in terms of e-mail that would come into that. And that was a distinct entity in an of itself. And when -- if they saw something that was concerning for that needed to be evaluated based on the patient care that we delivered, then that would come -- that would come -- could come to risk management. You know, a lot of the -- the vast majority of those complaints had to do with things that weren't, you know, didn't have a direct patient care application, it was more a lot of times as access to care. And then those would be addressed more with the administrators in the local area that were -- you know, if it was a problem with wait times in the ED, that would be -- that would end up going to the emergency -- the people around the emergency department.

Q. And have you held any other risk management positions at UMMC by title?

A. No. The only jobs that I was there was first the, you know, the Assistant Director and then the Direct -- I should say the Assistant Medical Director of Risk Management. And then Medical Director of Risk Management.

I should also say I did serve -- I -- I -- the hospital got -- or I should say the system had a -- has a Risk Management Committee, of which I was kind of the Chair Pro Tem, I wasn't the Chair, but if he wasn't there, I would run the meeting, and that's the meeting I was referring to before where we would review the cases that were being proposed for settlement.

Q. And you said "when reports come in," most of the time, there's a constant stream of when the report,

they're reviewed by nursing coordinators?

A. Yeah. The nurse coordinators in the risk management department.

Q. Okay. And, you know, I know you said -- testified earlier, it wasn't the sole reason for Dr. Papin's termination or that you, your opinion, that his termination should have been upheld, but because there were some allegations of patient care, deficient patient care, alleged deficient patient care by Dr. Papin, did it ever occur to you that maybe you should have some of your nursing coordinators who worked below you to look into the specific patient issues that were raised regarding Dr. Papin's care to determine if there was anything relevant that you wanted to bring up at the hearing or share with the other members of the panel?

A. I would say, no. First of all, I did not have extensive knowledge or I should say "I hardly had any knowledge" of the facts of Dr. Papin's situation until the hearing itself.

So the vast vast majority of my knowledge of what went on with Dr. Papin happened in that hearing that day.

Q. Would it be fair to say that your, at least substantive knowledge of the alleg -- the substance behind the allegations brought against Dr. Papin, that

you deem that from what was presented to you from Dr. Earl and the documents that he presented to you prior to the hearing regarding or substantiating allegedly Dr. Papin's termination?

A. I'm not sure I got those documents ahead of time. And that was something that I was discussing with Mr. Whitfield yesterday.

MR. WHITFIELD: I'm going to object to our discussions.

THE WITNESS: So I don't recall having those documents in advance, I may have, it was -- it was three-and-a-half years ago.

Q. (BY MR. SCHMITZ) Okay.

A. But I was -- I wanted to stay as open-minded as I possibly could going into that hearing. I didn't want to be -- I didn't want to get one side of the story unopposed. But I think the discussion was at -- as I said before, I think the discussion of the decubitus ulcer was reasonable. I'm not sure that the medical record -- there may have been some stuff in there, I don't know, I didn't look. I think that Dr. Papin actually did a very good job of pointing out his point of view of that incident in the hearing.

MR. SCHMITZ: I want to take a three-minute break. I need to go to the restroom.

(Whereupon, a recess was taken.)
Q. (BY MR. SCHMITZ) So at UMMC, you held two titles; correct, Assistant Professor in Pediatrics, Medical Director, Risk Management; correct?
A. Yes.
Q. Okay. And how did you divide your time up percentage wise between those two roles?
A. On paper, and we all know what that means; right?
Q. Sure.
A. On paper, it was I was 40 percent for risk management, if I remember correctly. But I would say that that -- that is probably -- was not a fair indication of my time. I would say when you actually looked at the hours that I spent, I probably spent 60 plus percent of my time doing risk management duties. And I use that time broadly as I described before, not the narrow just pure risk management, all of those chief medical officer team jobs that I did.
Q. And did you have two separate offices in UMMC?
A. No.
Q. Like doctor's office and then the --
A. No. Because everything is connected.
Q. Okay.
A. And, frankly, the office space was such a

pinch. And the office space was actually better in the CMO'S space, the room was bigger. I mean my first office was the size of like three phone booths put together. It was -- you couldn't have -- you couldn't have a visitor in my office originally.

Q. Okay.

A. Then it was -- then I was happy to give up my space because we didn't have enough offices for all of our faculty. But it wasn't very far away, I mean it was from -- like where some of my partners had their office space, it was, you know, 100 yards away. And from the tower where PICU was, the Pediatric ICU, it was probably 200 yards away. It was a quick walk.

Q. Did you ever consider whether those two roles at UMMC ever were in conflict of one another?

A. I don't know if "conflict" was the right -- is the right word. But there certainly were times when having both roles was stressful.

Q. Talking about your hearing experience, you know, conducting hearings regarding termination of employees at UMMC, where did you learn to conduct fair hearings involving those who UMMC sought to terminate?

MR. WHITFIELD: Object to the form.

THE WITNESS: Well I certainly had a lot of exposure to formal hearings in the legal system, which, of course, this wasn't. But in terms of law school as a practicing attorney and certainly as a law clerk, I mean I sat in the courtroom for a year. So I mean that's kind of a background that it had formed it.

In terms of kind of specifically what this should look like, that was based on my background. Like looking at the GME -- excuse me -- the ACGME document that was not very helpful and my conversations with counsel.

Q. (BY MR. SCHMITZ) Did UMMC have any manuals or anything to conduct on how to conduct hearings and stuff like that?

A. I do not believe so. I think there was some documents that came out kind of that overlapped this timeframe.

Q. Did you ever conduct any legal research into the substantive or procedural due process requirements for hearings and, you know, in termination context in the medical field?

A. No. That's what I relied on counsel for.

Q. And was that the same counsel who advised you on the format for hearings in the Dr. Eklund matter?

MR. WHITFIELD: I'm going to object to his conversations with counsel and talking to him on what counsel --

MR. SCHMITZ: Yeah. I don't want to know about the substance. I just want to know --

MR. WHITFIELD: Well you're asking about the substance.

MR. SCHMITZ: No. I'm only asking did he speak with the same counsel who advised him in the Dr. Eklund hearing as he spoke to in Dr. Papin's hearing regarding substantive due process. That's just a yes or no question. I don't want anything further.

MR. WHITFIELD: I think you're going into the topics of what they discussed.

MR. SCHMITZ: No. I'm not. I'm only asking --

MR. WHITFIELD: You asked him if they discussed due process, that's part of his discussion.

MR. SCHMITZ: Well he already said that. He already said -- he just said that.

Q. (BY MR. SCHMITZ) I just want to know yes or no was it the same legal counsel? I don't even care what their name is. Is it the same legal counsel that advised you how to conduct a hearing for Dr. Eklund and also advised you to conduct the hearing for Dr. Papin?

A. Can I answer that, Tommy?

MR. WHITFIELD: Let me think it through for a second.

MR. SCHMITZ: That's just like me asking him did he talk to you before the deposition, Tommy.

MR. WHITFIELD: I'm going to object to the form of the question, but I believe he's already answered that he did not conduct a hearing for Dr. Eklund. And I object to the form based on the premise of the question.

MR. SCHMITZ: So he can answer it?

MR. WHITFIELD: Yes.

THE WITNESS: The answer to your question is, yes, it was the same -- it was the same attorneys.

Q. (BY MR. SCHMITZ) Okay. And you testified earlier before, the IHL ruling and Dr. Eklund's case, you had no part of that, you knew nothing about that, that never came across your desk?

A. I can't say that I didn't know anything about it. I knew almost nothing about it. The only thing that I knew is that it happened. My first involvement with the matter involving Dr. Eklund was at the end. It was -- I know that there was several iterations, I had nothing to do with those.

Q. Okay.

A. I was asked to get involved at the last iteration.

Q. And I know that hearing never --

A. Pardon?
Q. That hearing for Dr. Eklund was set to take place -- I know it never did, but if that hearing would have taken place, you were asked to share that hearing as well; correct?
A. That is correct. But in terms of what came before, I knew that there was a lot of stuff that happened. I probably knew some vagaries, but I was not in -- I was not in the know in terms of the details with all the stuff that happened.
Q. Were you part of the process to give Dr. Eklund notice regarding the hearing and the allegations being brought against her and whatever relevant information or documents, which were given to her regarding her termination?
A. I don't recall the specifics. I may have been asked to put my name on a document informing her because I was the -- because I was the -- going to be the Chair of that committee. But in terms of the substance of what happened, no, I was not involved in that.
Q. I know -- so Dr. Eklund knew you were going to be involved in, then, obviously, there's Dr. Papin you were involved in, the appeal -- appeal hearing process, is it -- those were the only two, would these always come across your desk if somebody was in this kind of

situation, or were there other people who handled appeal hearings, you know, acting in a chair role at UMMC?

A. I have no idea. I was asked -- I was asked to be involved in these cases specifically. I have no idea about other hearings that may or may not have happened. I suspect they didn't because -- because I was involved --

Q. You would have been told --

A. -- I was involved with the Medical Staff Office too. I mean I helped them with some stuff, I was a sounding board for, you know, and a lot of that stuff is mine -- that they dealt with was minor. You know, how do I approach a conversation with this doctor. But to my knowledge, I don't know, there could have been a hearing, and I wouldn't have had any knowledge of it whatsoever.

Q. And so would it be fair to say, that it's relatively rare that a termination case comes to the Appeal Board for which at UMMC?

A. I would have no idea because I don't know what the denominator is.

Q. Got it. And how are you selected to be the Chairperson at UMMC for a hearing seeking termination?

A. I was asked by -- in Dr. Papin's case, I was asked by Dr. Woodward, the Vice Chancellor. I don't know how that decision was made to pick me.

Q. Okay. Are you aware of anybody else who would be the Chairperson of these hearings or --

A. I don't know anything -- I have no knowledge of any other hearings that happened, other than the ones -- the two we've discussed in terms of termination.

Q. I'm going to share an exhibit.

A. I'm not seeing it.

MR. WHITFIELD: It's in the chat.

Q. (BY MR. SCHMITZ) It's in the chat. You click the chat button. That's where the first Exhibit CV was.

A. I don't have a chat button. Let me change my -- no, that didn't do anything.

Q. It's like at the bottom, like there's a share screen button in the middle, and then to the left of that it's chat.

A. All I'm seeing right now is a stack of pictures. And it's got you -- it's me on top, the court reporter, whose name I don't know, I'm sorry. And you, then Tommy, and then the window with Dr. Papin and his gray telephone icon. Hold on, let me -- of course, I've got a MAC, which works differently than everybody else's computer.

Q. If you move the mouse, you know, like where you can pick to mute the video or stop the video.

A. None of those -- none of those boxes are on my screen.

Q. Okay.

A. Let me just -- maybe I've minimized something.

Q. Yeah.

A. Let me experiment here.

Q. It would be the same place where you were able to pull up your CV.

A. Yeah. And that's gone now. So there was an Adobe -- that loaded Adobe Reader for me to pull that up. I'm going to close that one down.

Q. Here, I'll resend it, maybe it'll prompt, and you can see it again.

A. Oh, well that was interesting, that just moved it on top. Hold on. Stop video, mute my audio, pin rename, hide self. That just moved my window.

MR. WHITFIELD: Greg, why don't you just share the screen.

MR. SCHMITZ: Personally, I don't know how to do that, Tommy. Personally, I don't know how that works. I'm a one-trick pony. I post it in the chat, and then we talk about things. 'Cause I still don't know how to use Zoom, so I just stick to what I know.

THE WITNESS: I don't know what I've done

with this. Do you want me to quit and rejoin?
MR. SCHMITZ: You can if you want. Yeah. Just quickly.
THE WITNESS: Maybe that's what we'll try. Of course, it didn't quit.
MR. SCHMITZ: You've got to click the red --
THE WITNESS: Hold on. Hold on. We're getting somewhere now. Sorry. You want me to go to E-mail-Papin Complaints.pdf?
Q. (BY MR. SCHMITZ) Yes.
A. All right. We're making progress.
Q. Touchdown.
A. All right, I'm ready, I can see the document.
Q. Okay. So this at the top here, we'll go through it all. But at the top here, this is an e-mail from you to Darlene Bryant?
A. Yes.
Q. And you said Darlene was who again?
A. Darlene is the Director of Risk Management. She was the nurse who was in charge of a lot of that stuff we were talking about before. So she would be my -- she was like my -- I mean she didn't technically work for me, but she kind of worked for me. She worked for the Chief Medical Officer.

Q. And why were you asking her to check anything in the system about Dr. Papin, the complaint data bases and whatnot?

A. So I'm making a supposition because I don't remember this at all.

Q. Okay.

A. But based on this, it was not uncommon for people to ask me, "Hey, did you hear about this event or did you hear about something." Dr. Earl and I knew each other because of our positions at the hospital. He wasn't a friend of mine, he was a work colleague. What I suppose -- what I believe happened was he said "Can you look and see if there's anything about this resident in our data bases." So that's why I asked Darlene because I didn't -- I didn't quarry those data bases myself. Because I wasn't really in that level of -- at that level, I was kind of -- it sounds conceited -- but I was above -- I was above that. Right. The people that worked for me and with me did that.

So Darlene would go in and then could search on that name. And, of course, what you can see here is that she's looking in both -- would be looking -- when I said "our system," that was the iCARE event reporting system. And she also could -- I don't remember if she had to do it directly, I think she could or would have had somebody in the patient relations search the patient complaint data base. Unfortunately, they were different, which was a source of frustration for us because it made our jobs harder. We wanted to have them do both, but it wasn't practical to do that.

Q. And if you -- so there's three pages in this pdf. Page three of three in the pdf all the way at the bottom?

A. Yes.

Q. About two days after you sent the first e-mail inquiring regarding whether there was any reports, you came to the conclusion that Darlene had looked in both the iCARE data base and patient care data base but found nothing on Dr. Papin; correct?

A. I don't recall sending that e-mail. I have no reason to doubt that that's what happened.

Q. That is your sbondi@umc.edu, that would have been your e-mail?

A. That absolutely is my e-mail. So, yes, I believe that that is correct.

Q. Okay. And were you prompted to look at this because Dr. Earl had raised concerns regarding patient care regarding -- with respect to Dr. Papin?

A. Having no specific recollection of the conversation, I can't answer the question directly. But what I -- I can't say yes or no. But what I can tell you is, I really believe that I would have remembered that conversation had he said, "Hey, there's like a major problem with this resident, can you look up and see if you have anything." I would have remembered that. So to the best of my recollection, no, I think he just asked me if there was anything there.

Q. As a Director of Risk Management, I'm sure you get complaints, you do get complaints or lawsuits based on where patients are alleging that residents provided them with deficient care, you've seen other cases regarding that; correct?

A. Well, usually, as you well know because I'm sure you write the pleadings, they're not that -- they tend to be fairly broad and inclusive of all the care.

Q. Sure. But sometimes that is alleged to, you know, have you ever been involved in a case where it was clearly the residents' fault or something like that, that they just dropped the ball because of lack of knowledge or training or experience?

A. We don't really think of it that way. I mean as you mentioned before, the residents are all supervised, so it's not that simple.

Q. So in terms of bearing the brunt of the responsibility for patient care, that the buck stops

with the attending physician; correct?

MR. WHITFIELD: Object to the form.

THE WITNESS: Ultimately, the attending physician is involved in the medical decision making for that patient. Clearly, hypothetically, and I'm sure this is borne out by many many cases, that doesn't mean that errors don't occur. And the nature of the way medicine works, it's that the attending physician can't be directly involved in every single aspect of the patient care.

So, yes, ultimately, you're responsible, but errors occur at all levels.

Q. (BY MR. SCHMITZ) In any of the cases that you handled as the Director of Risk Manager or that you reviewed as the Director of Risk Manager at UMMC, was there ever a case where you concluded that the resident had made a medical error and perhaps recommended that UMMC -- I don't want specific -- but that UMMC, you would recommend that they settle that case as a result of that error?

A. I don't recall a case that was that narrow involve -- you know, that was that narrow that even the resident was the major issue.

Q. In cases where the resident was a contributing factor maybe and not being so narrow where they were the

specific issue and the only issue?

A. There certainly were cases where the residents -- the residents were contributing to the cases, yes.

Q. In those cases, were the residents terminated for the alleged contributions to the deficient patient care?

A. I don't know. But once again, it's not that -- it's typically not that narrow. And, frankly, from Risk Management's standpoint, we're looking at cases from a different angle. You know, the angle is what is the risk to the institution. So who did it is less important. And, frankly, from our approach of safety and delivering high quality care or the who, you know, in terms of those decisions, we're looking more at -- more of the big picture.

Q. Well wouldn't you be concerned in terms of the risk to the institution if you had a resident who was caring for patients and doing deficient work, that they would continue to do that if allowed to continue their employment at the institution?

A. Yeah, of course. That's -- doesn't -- that's not usually -- or I shouldn't say "not usually." That's typically not what it looks like. You know, I don't -- nothing ever -- no one ever brought to me outside of this case, which was very unusual because my involvement wasn't really as the risk management person, it was as a Member of the Graduate Medical Education Committee, which is a different role all together.

That's -- I don't recall a case coming to us, "Oh, this resident did this, what should we do about it." That's not -- that's not what we did. Those things go through the residency program or they go through Graduate Medical Education Office/Committee.

Q. So sitting here today, you don't recall who had asked you to look up the complaint data base on Dr. Papin?

A. Well based on my e-mails, I would suspect it was Dr. Earl. I don't have -- like I said before, I don't have a specific recollection of that -- of being asked. And the reason is, is because I got asked many many times to look up particular events to say, hey, by the way, do you know this thing happened. And then the first thing I would do would be either go to Darlene or in person because her office was right next to mine. And that's the way I usually did it. Why was this done via e-mail, it might have just been because I bumped into Dr. Earl in the hallway, I don't know, and I did it on my phone.

Q. Okay.

A. Just because it was -- so I didn't forget.

But it was very very common for people to ask me if I knew about something. That was kind of their, you know, sometimes their way of going to me, "Hey, you know, there was this event in the OB/GYN yesterday, do you guys know about it." And then the answer is I don't know. Because I wasn't in continuous contact with the nurse. You know, the nurses that work for me.

Q. Following your e-mail here in the Exhibit to Dr. Earl on January 22nd, did you have any further communications regarding Dr. Papin's performance or conduct with Dr. Earl?

A. Not that I recall. I assume you mean until the actual hear -- until the actual hearing process stopped -- started?

Q. That's correct?

A. Yes. Not that I recall.

Q. Right. Did the fact that there was no iCARE or patient complaints or any other types of complaints that you were able to find on Dr. Papin, weigh at all on your decision to uphold Dr. Papin's termination?

A. No.

Q. Why?

A. Because the iCARE data base is not really for many of the things that involved Dr. Papin. The iCARE data base is sometimes used for professionalism and conduct, but the vast vast majority of things are not put in there. Mainly, because there are other -- there are other channels that those are addressed. If somebody had a problem with me as an attending physician, the appropriate avenues would be to talk to my boss, the Division Chief or my Department Chair or to take that issue to the Medical Staff Office. For a resident, that would be to take that up with the Program Director or the Department Chair or the Graduate Medical Education Office. And nursing had their leadership chain as well.

So the event reporting system is not typically used for this. And for patient complaints, those are completely different. And there's tremendous research done in this space showing that, you know, patient complaints and interpersonal professionalism things are completely different. And so it's not -- it would not be unusual for someone to have interpersonal problems with co-workers, yet not have problems with patients. That's very -- that's very common and well described.

Q. Had Dr. Earl raised during your conversations prior to him requesting the documents to -- if there was anything on Dr. Papin, did he ask you to look into any specific issues of patient care that he was specifically looking to target?

A. Not that I recall.
Q. Okay. I sent over the next exhibit in the chat. Hopefully, it easily pulls up. Do you see it?
A. Let me click through my boxes here. I don't know -- I don't even know how I pulled up the last one. Yes. Yep. You're talking about Eklund Records.pdf?
Q. Correct.
A. All right. Yep, it's loaded. That was much easier this time.
Q. Good.
A. I can see it.
Q. Okay. Do you know who -- I guess the first letter in this is authored by Vince Herrin, MD, who's been appointed as the temporary Chairperson for the Committee on the Academic Freedom and Faculty Responsibility?
A. I don't know, I've never seen this before, to the best of my knowledge. This was -- I was only at the medical center for a few days in September of 2014. No, that's not right. I'm sorry. I have my dates wrong. So I would have been there for about a year. I don't believe I've ever seen this document before.
Q. What about the document that starts on page 3 of 12. It looks like a letter from David Norquist Law, have you ever seen that before?

A. I do not believe I have seen this before.

Q. Page 10 of 12 of this PDF is where I want to go to.

A. I'm trying to figure -- oh, there it is. Okay.

Q. It says: "Minutes of the Board of Trustees of State Institutions of Higher Learning March 17th."

A. Yes. I'm looking at that document.

Q. Okay. This was the minutes from the IHL I guess meeting or ISLH -- IHL's findings?

A. Okay.

Q. Were these presented to you, this was in 2016, were these presented to you when you were the -- supposed to be the Chairperson over the hearing, I know it never happened, but in your involvement in Dr. Eklund's case?

A. I do not recall. I don't believe so, but I -- I -- I'm not sure.

Q. Okay. And in the second paragraph of that letter, it starts: "The Board then discussed and deliberated regarding the institutional record and issues raised by Dr. Eklund in conducting its review of her proposed termination by the UMMC. On motion by Trustee Pickering, seconded by Trustee McNair," et cetera et cetera. "All those legally present and

participating voted unanimously to direct UMMC to provide the following to the above mentioned employee: an additional due process hearing with the right of confrontation, to deliver adequate notice of documents to be used in the hearing as well as copies of such documents in advance of the hearing. A hearing officer who is either knowledgeable in due process matters or has access to legal counsel during the course of the hearing to ensure a fair impartial hearing, and to have the University to consider all other issues raised by Dr. Eklund and any appropriate course of action."

Do you know, in this case, whether the right of confrontation was given to Dr. Papin during his hearing.

MR. WHITFIELD: Object to the form.

THE WITNESS: Can I go head and answer it, Tommy?

MR. WHITFIELD: If you can.

THE WITNESS: Yeah. So Dr. Papin had the opportunity to see the witnesses. Or I shouldn't say "see," I apologize, he was on the phone. Had the opportunity to hear the witnesses. He had an opportunity to raise issues with what they said.

Q. (BY MR. SCHMITZ) Not directly though; right, they were --

A. It was not direct. That is correct.
Q. And he -- in all the questions that Dr. Papin asked or brought issues for, did the panel or you as the Chairperson of his Appeals Committee ensure that those questions that he posed or issues he raised were addressed with the people specifically at the hearing?
A. Well using that degree of exclusive language, I would have to say no because you said "all and ensure." Dr. Papin mostly talked rather than raise specific, you know, like say, you know, I'm curious as to what they would say about this. We did ask questions, we asked -- we clarified what people said.
Q. Was there any IHL Board involvement in Dr. Papin's case or directives given in Dr. Papin's case regarding his hearing?
A. Not to my knowledge.
Q. So based on what the IHL says here, what is your understanding of the right of confrontation, what would that encompass?
MR. WHITFIELD: Object to the form. You can answer the best you can.
THE WITNESS: Yeah. I think it would have -- they have the opportunity to hear what the person said and rebut what they said.
Q. (BY MR. SCHMITZ) And as the hearing officer

for Dr. Papin's hearing, did you take any of these IHL directives, which came before Dr. Papin's hearing occurred into account in Dr. Papin's hearing and the procedures that are format and you used for his hearing?

A. Well this IHL document is specifically about another person. And I do not believe that I saw it. So the answer is, no.

Q. Do you believe that Dr. Papin was delivered advanced notice of all documents to be used in the hearing as well as copies of such documents in advance of the hearing?

A. I don't know the -- I don't know.

Q. Did you ever ask anyone else whether he had received all those documents prior to conducting the hearing to ensure that he was getting a fair hearing?

A. Well I know that he got some because his attorney is the one that gave me the documents at the hearing.

Q. Who would have been taking part in that process to ensure that he was getting all the documents that he should have had in order to properly rebut the allegations against him in this case?

A. Well I assume his attorney.

Q. Right. But his attorney wouldn't be giving the documents. His attorney would have received those

documents.
A. Right.
Q. Who at UMMC was responsible for providing Dr. Papin the documents he would need to rebut the allegations?
A. I don't know. But Mr. Dillard his attorney is the one who -- he actually specifically pointed out things in the documents. And I didn't have the documents in front of me at the hearing. He's the one that provided them and the bates numbers.
Q. So to the best of your knowledge, you as the Chairperson of the hearing and no one else on the panel had any responsibility or oversight over the process of providing Dr. Papin the documents in advance -- the relevant documents in advance of the hearing?
A. Certainly, none of us did. That's correct.
Q. And you have no idea who would have done that?
A. I do not know. But I know what happened.
Q. So because you had no involvement, you're not sure whether he received a complete set of the documents in advance of the hearing that might be relevant to rebut the things that were brought up at the hearing, so he would not be ambushed by certain things that were going to be brought up?
MR. WHITFIELD: Object to the form.

THE WITNESS: I don't know what he received.

Q. (BY MR. SCHMITZ) Did you ever have any meetings between Dr. Eklund's counsel, Mark Ray and yourself regarding that matter or that case?

A. Yes. And Mr. Whitfield was there too.

Q. Are you able to discuss what was discussed at that meeting?

A. I remember the meeting distinctly. I -- there was something about one of the attorneys on the other side that I just -- I remember his face. Nothing good, nothing bad, I just remember. Because it was two -- it was two attorneys for Dr. Eklund. And we were -- I think our primary thing was discussing timing. I recall that Dr. Eklund's attorneys wanted to move this process along quickly. And so we were -- we were narrowing down on timing, and we talked a little bit about the -- what it would look like. But we didn't get into a tremendous level of specifics.

Q. And UMMC never ended up conducting Dr. Eklund's hearing; correct?

A. To my knowledge, no. I believe the case got settled. And it was actually we were ready to go -- we were getting ready to do the hearing, and then they sued us to stop the hearing, which was ironic because they asked for the hearing.

Q. All right. They sued to stop because of alleged due process concerns and lack of notice and stuff like that?

A. I don't recall what -- what it was. But I was -- I wasn't upset about it. I was amused may be the wrong word, I found it ironic, that they were pushing us very hard to hold this hearing, we talked to them specifically, we got everything in line, and then the next thing I know, I got served -- I got served by the Sheriff to unjoin the process. And that was really the end of my involvement.

Q. Okay. The next exhibit I've just posted in the chat.

A. We'll give this a shot.

Q. It says "E-mail-Thread discussing hearing."

A. Yep. I'm pulling that up now. I can see it.

Q. When did you first learn of Dr. Papin's Appeal Hearing?

A. I can't give you an exact date. I believe that it -- knowing when this e-mail thread started, I believe that I was given a heads up probably in late June or early July, that there was a matter that they were going to want me to be -- that I was going to be asked to be the hearing officer for. But that their --

they didn't want me to like get involved in it. They wanted me to just be kind of standing by. Probably, looking, you know, what's my timetable because as an ICU doctor, I have clinical obligations and patient care responsibilities, and they needed to make sure that my schedule didn't have a conflict or whether I could remove that conflict or the timetable.

Q. How were you notified that you were going to be part of Dr. Papin's appeal hearing?

A. I believe my first -- and I'm excluding this e-mail -- well, obviously, the e-mail wasn't talking about the hearing, but about the appointing system. I believe that Mr. Ray gave me heads up about it, University counsel.

Q. And it says Dr. Woodward appointed you as the Chair. Did Dr. Woodward talk with you, that, hey, you're going to be a pointed chair at this?

A. No. Dr. Woodward is like six levels above me in the institution. It's -- she didn't have a conversation with me about it. There may have been a -- there may have been a letter asking me to serve in that role, I don't recall.

Q. And in the very -- the last day five of five that kind of starts off this e-mail chain to you -- you to Bryce Ainsworth. Who's Bryce Ainsworth?

A. Best as I can recollect, she was the Administrator of the Graduate Medical Education Office.

Q. Okay.

A. So that would include all the residents and fellows of the hospital. It's a -- it's a lot of work because there's a lot of compliance issues surrounding what you need to do for medical education.

MR. WHITFIELD: Greg, can I have 30 seconds? Somebody's banging on my office door.

MR. SCHMITZ: Sure.

MR. WHITFIELD: Hang on. Sorry.

Q. (BY MR. SCHMITZ) So in this first e-mail, you're asking Bryce: "Do you have any documents," -- which you say: "Second, do you have any documents which detail the process for evaluation, termination, and appeal of residents." Do you recall whether Bryce ever provided you with any documents?

A. I don't believe so. I think at some point, there was this document I referred to you before which was like this standard that was being implemented since all of this happened.

Q. Okay.

A. It was very brief and it wasn't particularly helpful.

Q. And then you say, "Finally, I perused the

ACGME website and could not find any requirements for appeal in the case of termination. Are you aware of any ACGME standards that would apply in this case?" Did she ever respond back to you to let you know about this?

A. I don't believe she had anything.

Q. And you said they weren't very helpful. But do you recall what the ACGME said about appeal hearings?

A. I don't even -- I don't even remember right now here as we sit here today.

Q. She responded back to you giving you a spreadsheet. I guess that's three or some members of the GME committees. She says, "I've also attached our new protocol for appeals, which includes a list of "sitting" members to choose from if you wish."

So were the new protocols for the appeals, was that as a result of the incidence which happened from issues that were experienced with Dr. Eklund at Dr. Eklund's Appeal Hearing?

A. I don't know the answer to that question. GME has nothing to do with faculty. So, you know, the faculty you're -- that's govern -- it's a whole different system. You know, faculty are, you know, they're univer -- that goes through the university system. House staff are essentially students, they're paid, but they're students.

Q. And she said: "I have a couple of questions. I thought Papin's case was being decided to be an employment instead of academically-related, which would change the scope of the process of the appeal from GME to HR." What is she talking about there?

A. Well I think she -- I'm -- well what I -- I can't say what she was thinking. I can say what I interpreted her to mean.

Q. Perfect.

A. And that would mean I -- I think that she was perhaps not understanding that this -- I think she was just thinking about what had happened in January and February with HR. I don't think she was thinking that -- that there would be an appeal. I -- that would be my supposition, that she thought that HR, that was the end of it.

Q. So with HR, there's typically not an appeal, but because he was -- Dr. Papin was part of the GME, Graduate Medical Education Program, he was entitled to certain rights of appeals because it was -- -

A. I don't know the --

Q. -- terminating his residency?

A. -- answer -- I don't know the answer to that question. But the rules for faculty are different for the rules for employees. Pure employees, they're different for house staff. That would be different for medical students. It's -- it's -- they're apples and oranges. And I don't know -- you know, I don't know about HR, how HR fits into this at least at that point.

Q. So as a medical resident though, you get the, you know, the protections and rights that go along with being part of the Graduate Medical Education Program; correct?

A. Well I don't know if there are any rights. I mean I -- you know, specific. It's not like they're written down anywhere, at least to my knowledge.

Q. But you're suppose to follow if you're -- if there's ACGME standards which would govern how things are conducted in a medical residency program; correct?

A. Yes. There are all kinds of standards that deal with, you know, anything for what you're suppose to know when you graduate from your pathology residency to how many hours you can work, there are a lot of different rules.

Q. And that's different from just what a normal employee would be at UMMC?

A. Oh, yes, yeah, completely different.

Q. And, obviously, so as a resident like you were just alluding to before, they're both, you know, the part of the Graduate Medical Education Program, but yet

they're also employees of the institution -- employees of UMMC?
A. Yes.
Q. So they would both arguably -- I know you don't know what all the rights or whatever are, but as a medical resident, they have rights as a medical resident and then rights as an employee; correct?
A. Theoretically, yes.
Q. Under UMMC's Policies and Procedures?
A. Yeah. I don't know if "rights" is the right word. But I see what -- yes, they would fall under both categories.
Q. Okay.
A. But they're not necessarily mutually exclusive either. I don't --
Q. Right.
A. And I think that was part of the confusion here at least at first.
Q. Right. But, you know, like in terms of let's say if a medical resident would have more protections or rights in this kind of circumstance than just a regular employee, then you have to default to the additional layers of protection because he would be entitled to both as an employee and a resident; correct?
A. Yeah. Yes.

Q. All right. Going up to page three of five of this PDF. I know there's some like black things that were privileged material here. But there's an e-mail from you on July 11th at 10:15 a.m. to Rick Barr and Bryce Ainsworth?
A. Yes.
Q. And you're saying, "Rick I have not been involved in this process until late last week. That was intentional in order to keep my knowledge of the matter minimal. I was not involved in the decision to channel this through the GME appeals process. The VC has appointed me to chair." That's the Vice Chancellor Woodward?
A. Yes.
Q. "And notice has already been sent to Papin's attorney." Was Dr. Barr of the opinion that you should not or that Dr. Papin should not have had an appeal under the GME processes?
A. I have no idea.
Q. And you say that you were not involved in this until late -- but there was e-mails earlier where you were asked and provided information regarding Dr. Papin allegedly having some kind of patient complaint issues back in January; correct?
A. I would not characterize that e-mail as that

such. First of all, when I said I was involved in the process meaning the -- this -- this appeal. And all I was asked to do in that -- with that e-mail back I believe in January was, is there anything here. That was purely -- I was purely a conduit to see if there's any information in the data base for Dr. Earl.

Q. Did Dr. Earl when he was asking you for the information, if there was anything in the data bases, did he ever ask you like specifically like was there any complaints about the decubitus ulcer patient that we've been talking about for most of the day today or any of the other patients that Dr. Papin may have seen that he wanted you to focus on?

A. Well as I said before, I don't have any specific recollection of my conversation. But I think the reason I don't is because it was so minimal and so typical of many of these request that I got. If there was a specific issue about a complaint, I believe I would remember that.

Q. Are you aware of whether Dr. Earl was ever advised that an iCARE report should be filled out regarding the decubitus ulcer patient?

A. No idea.

Q. If someone like Dr. Earl was advised by someone in HR or somebody else to do something, submit

an iCARE report regarding, let's say; for instance, a decubitus ulcer patient, would there be any reason why he would not do that?

A. I would assume that most of us have a reason for everything that we do. I think that's too many degrees in speculation for me to comment on.

Q. If Dr. Earl did submit, you know, an iCARE report regarding the decubitus ulcer patient in Dr. Papin's care of that, that would have triggered an investigation, someone to review the medical charts for that patient at a minimum; correct?

A. No. Because it certainly somebody would have read the report and determined whether further invest -- whether an investigation was warranted. But the mere presence of an iCARE report doesn't trigger an investigation. I mean we get -- you know, I believe the volume that we were getting at this time was 600 to 800 iCARE reports a month, which is actually very low for an institution of our size.

So we didn't investigate every single one of those issues. And it would be unusual in the circumstances you described for a program director to put in an iCARE report about patient care for a patient he wasn't intend -- attending on.

Once again, as I mentioned before, the iCARE reporting system isn't really set up for -- for that kind of -- for issues about people other than the patients. The purpose of it is an event reporting system, it's running patient safety events. So it's really the people that are caring for the patient that put in those notes. So the nurse, the resident, the attending physician, you know, put them there.

So to ask Dr. Earl to put an iCARE report in for something he already knew about and was addressing, that's not really what the system is designed for. Do people use it for stuff like that sometimes, sure. But that's not what its -- that's not what its primary purpose is.

Q. Is there another report -- sentinel reporting system that y'all used in risk management or you get in sentinel reports regarding patient care or --

A. I don't know --

Q. -- adverse needs?

A. -- what that means. I don't know that phraseology.

Q. What is the primary channel then which adverse patient outcomes are reported to Risk Management then, other than iCARE?

A. Events will be -- I think you may be misunderstanding what I just said. The patient care events will be reported through iCARE. But reporting on an individual person's actions after the fact that somebody already knew about, wouldn't necessarily show up on iCARE. So reporting a decubitus ulcer in iCARE would be fine. You know, that would be -- that certainly does happen, and did happen. But what you asked it whether there should have been an iCARE report because Human Resources asked Dr. Earl to put an iCARE report about something, that doesn't seem quite right to me.

Q. But anybody can submit an iCARE, so HR --

A. Right. Right. But Dr. Earl --

Q. -- can submit an iCARE report?

A. -- already -- but, basically, Dr. Earl would have put in the iCARE report, which would have been channeled back to him. So that's not really what the system -- looking at just the decubitus ulcers, that would have been a reasonable thing to have an iCARE reported. And whether or not those get reported, is kind of an aspect of the culture of a given institution.

But I'm talking about the personnel aspects of this, that's not typically something that gets reported that way, it does sometimes, but most -- I would say in my experience, in my four years at UMMC -- most of those problems with interpersonal issues don't go through the iCARE system. They go through the chain -- the normal chain. If there's a problem with the resident, someone talks to their -- might talk to their attending on service then but, ultimately, would talk to their program director. Does that make sense? So it's all coming back to Dr. Earl anyway as the Program Director for surgery.

Q. But had an iCARE report been submitted by Dr. Earl, I'm not saying it's a given that it would have happened, but if there would have been, then the possibility that somebody would have reviewed the decubitus ulcer patient's records independent of Dr. Earl to make an assessment of whether this was a potential -- whether there was potential legal or exposure to the institution; correct?

A. All of that -- well --

Q. Potentially? I'm not saying it for sure would have happened. I know that somebody's --

A. The goal of the --

Q. -- got to be involved in that first.

A. -- events of that -- the goal of the event reporting system is not the protection of the exposure of the institution. The goal of the event reporting system is to collect information, so that we can engage in our continuous efforts to improve patient safety and quality of the care that we deliver.

That being said, to answer the other part of the question, every iCARE report that got put in, every event report that got put in would have been reviewed. The vast majority of those would have been handled at the level. So if someone put it in for, you know, the fourth floor south or whatever it is, then the nurse manager in that area would have been the person that reviewed that. For decubitus ulcers, those would have stayed at that lower level.

Q. So there would have been further review by like the wound care nurse and team and they --

A. Maybe.

Q. -- would have said what happened with this person?

A. The nurse manager in that particular area is the person that is responsible for evaluating that report and doing something with it, depending upon what it is.

Q. Okay.

A. So that disposition could be anywhere from typing a comment into it, you know, I discussed this matter, you know, or, you know, with the lab, and that might be the end of it. An often -- most often those issues. The vast vast majority of these are addressed and closed out in the event reporting system by -- by at that level.

Our team would review those. But a simple decub -- I should say "it's not a simple ulcer," but a decubitus ulcer is not the kind of thing that would routinely bubble itself up for a deeper analysis by Risk Management.

Q. But it could happen, there's possi -- it does sometimes get bumped up?

A. It could if it -- it could if it were -- if there was something special about it.

Q. Okay. Like a decubitus ulcer that required surgical intervention or something like that, that would --

A. Well probably not even that. Because that would probably go through the evaluation process on the unit and the -- and on the -- with wound care. They certainly -- those certainly didn't rise to my level. Certainly, there are certain aspects of who pays for that. So that might have bubbled up, and a lot of times Darlene Bryant would facilitate that in terms of saying, you know -- you know, should someone have to pay for this additional care or not. And there's special rules about that too.

Q. Okay. I'm sending over the next exhibit.

A. I'm still having trouble figuring out which box I have to click to pull it up. Oh, there it is. Appeals Protocol.pdf?

Q. Yes.

A. I am looking at this.

Q. Do you know who created this document?

A. I do not.

Q. So it says: "The charge for the committee is to review the case documents." Then it says: "Evaluations, remediation plans, applicable e-mails, et cetera. Discuss the issues at hand separately with the program director and the resident requesting the appeal, and then determine if due process was followed in making the adverse decision."

So what does "due process" mean, and how were you able to uphold the termination and to determine that due process was followed in Dr. Papin's case?

A. Okay. So first of all, I don't know I've seen this document before, but I may have. So the question was, did -- would the individual in question, in this case Dr. Papin, have had the opportunity to, you know, know what the deficiencies were -- let me -- I'm sorry, I need to ask you a clarifying question first. You're talking about the decision to terminate, not the appeal process?

Q. No. I'm asking how did you -- it says you were charge -- essentially, that the charge for the committee is to review the documents, discuss the issues with the PD and the resident, and then determine if due process was followed. So what determinations --

A. So in making --

Q. -- regarding due process did you make in upholding Dr. Papin's termination?

A. So this -- my understanding, and I could be wrong, is that this document was not in place when Dr. Papin was terminated. I mean the date on it is April 28th, 2017.

Q. Yeah. So it was.

A. I'm sorry?

Q. His appeal hearing was in July -- his

A. Wasn't -- wasn't he terminated in February of 2017?

Q. But his appeal was not until July of 2017.

A. I understand that.

Q. Right. So he wasn't -- he was still under appeal, he formally terminated until you appealed his termination in July.

A. I don't know whether that's true or not.

Q. But this is about appeal -- the appeals protocol. This is Appeals Committee Graduate Medical

Education. So the question again is: What did you determine and what determination did you make as the Chair of Dr. Papain's Appeal Committee that due process was followed specifically with respect to his termination?

MR. WHITFIELD: Let us object to the form of the question because that leaves off half the sentence.

Q. (BY MR. SCHMITZ) Okay. You can answer.

A. So in terms of the termination itself, not the appeal of the termination, Dr. Papin was given frequent feedback in terms of what his deficiencies were. He was given an opportunity to address those on multiple occasions, both by having a conversation about it, but also by changing his conduct over the course of his six months up until that time.

Q. Are you aware if Dr. Papin was ever placed on a remediation plan?

A. I know that there was a discussion about it before the matter was reviewed by HR. What I can say is that the hearing was in reviewing it, was, you know, that's a different thing, but the due process at the hearing itself.

Q. In terms of if, do you recall if Dr. Earl and Dr. Papin did agree on a remediation plan on January

10th of 2017?

A. Yes.

Q. Do you know if Dr. Papin ever worked a day at UMMC after January 10, 2017?

A. Yes. When I talk about remediation, I'm not referring to that. I'm talking about the remediation -- I'm talking about all of the evaluations, all of the conversations from July through January. But the answer to your question is, my understanding is that after that meeting, Dr. Earl -- and I believe after in discussions with Dr. Barr, they determined that that was something that needed to go to Human Resources.

Q. Is that a deviation from the normal GME processes in terminating somebody who's subject to the GME -- GME rules for termination?

A. I don't know if there is a normal process. Because it is highly unusual to have a resident terminated.

Q. Right.

A. But my understanding is the GME process is really focused directed to be, you know, it's -- I should say it's anticipated as academic issues, not like professional HR issues. So as you had mentioned before --

Q. It's usually a --

A. -- it's a hybrid. It's --

Q. Resident -- resident terminate -- would it be fair to say, resident terminations are -- they are rare because most of the time, they are -- residents are provided with a chance to remediate their conduct, and they're given a formal written, you know, for a lack of a better term, performance improvement plan, and then they're given the chance to, you know, say, okay, I hear the things that you believe my -- why my performance is deficient, and I need to improve on these for the next 90 days, and if I don't, then I'm out, if I do, then I get to continue, isn't that usually the process that takes place in almost all resident -- in resident disciplinary actions?

MR. WHITFIELD: Object to the form.

THE WITNESS: And I can answer; right?

MR. WHITFIELD: Yes.

THE WITNESS: Okay. First of all, understand that the basis of my knowledge is not data. The basis of my knowledge is kind of the culture that I am aware of at UMMC and other institutions.

Q. (BY MR. SCHMITZ) Right. That's fair.

A. So it's not like I've read a paper that says this is the way it happens. The vast vast majority of residents that struggle, have academic problems. So they either have problems with knowledge, or they have problems with skill. Or they have problems with their ability to do the work in terms of like efficiency and getting things done.

So if you don't pass your inservice exam, the residents take an exam every year to show that they're meeting their knowledge base, then they'll -- then there will be a remediation plan. You need to read. I mean if there's more to it than that. Maybe you need someone assigned to you. If they, you know, and -- so that would be the most common area would be knowledge base.

There's also residents that frequently struggle in terms of their just sheer ability to get the work done. They need more skills in terms of how do I see X number of patients, or how do I fit this all together. That's something that usually comes along with time. Right.

So there's also an expected trajectory for residents; right. You don't expect the same thing for a fourth year resident as you do for an intern. So the expectation's in terms of skill are very low for an intern. The actual -- the expectations for knowledge base for an intern are very low. But the expectations for professionalism and interpersonal relationships are really the same for a resident as they are for a lot of the employees.

So that's a -- that's a different thought process when you have significant issues with professionalism and interpersonal relationships.

Q. So are you saying that if someone has interpersonal issues with other people, that that is not something that anyone could be remediated or rehabilitated if those things are brought to their attention specifically and are dealt with?

A. No, I'm not saying that. What I'm saying is it's a different -- it's different. And that the focus is different. And I think in this case, you know, we can talk about the specifics of those, if you'd like, I mean Dr. Papin was giving multiple, multiple, multiple on multiple occasions giving feedback regarding professionals and communication issues, starting in the first month of his residency.

Q. I want to get back to what I was asking before, which was, for purposes of the appeal process, how did you determine that he received due process in the appeal process?

A. So we reviewed, and we specifically addressed in the hearing --

MR. WHITFIELD: Object to the form of the question, but you can answer.

THE WITNESS: -- that Dr. Papin had had monthly feedback, had had frequent conversations with Dr. Earl about his deficiencies, both formal written feedback from during his rotations, conversations about that monthly feedback, as well as in I believe in November of his intern year, his first year of residency, that he received a formal summative evaluation of the first half of his residency.

So he received notice of what his deficiencies were, he had an opportunity to discuss those deficiencies, he had an opportunity to, you know, discuss those specifically with Dr. Earl. And he had an opportunity to remediate that entire -- that entire time.

Q. (BY MR. SCHMITZ) Anything else?

A. Our review -- in our review, that was notice an opportunity, and that he had the due proc -- that that constituted due process in terms of his termination.

Q. But we've been talking about HR versus GME and professionalism issues, and we talked earlier, and you said -- I asked you what's the professionalism issues, and you said, well it seems like he may have been lying about whether he was doing his rounds, you know, basically attending to patients, and that really

centered around that allegation and regarding whether he ever looked at this decubitus ulcer patient's back to see if there was a decubitus ulcer back there. And they believe he was not being truthful about that.

What investigations, if any, did you order or look into further into those issues to determine whether that was accurate or not?

A. We didn't -- that wasn't our role. Our role was for review. It wasn't to -- it wasn't to be the investigator. Our role was to review the decision and give an opportunity for -- for -- to hear what the witnesses had to say. And to give Dr. Papin an opportunity to -- Dr. Papin an opportunity to hear that and rebut it. We heard --

Q. Right. And Dr. Papin never agreed --

A. -- we heard it first -- we heard firsthand from the witnesses.

Q. -- with those. Right. He denied agreed with what those witnesses -- he denied what those witnesses were saying, he denied not seeing the -- he denied not caring for the decubitus ulcer patient. He denied not doing his pre-rounds and rounds when other people said maybe he was showing up later; right?

A. Well, yeah, he did deny it. Like I said, twice -- at least twice before, I think that the -- you know, he gave a well-thought rebuttal about the decubitus ulcer, that's in the record, that was in the record. So, yes, he did deny it.

Q. But he was fired because he was a danger to patients according to HR; right, so was there any investigation regarding how -- why he was investigated, you know, he denied that he was a danger to patients, HR said he was.

MR. WHITFIELD: Object to the form.

Q. (BY MR. SCHMITZ) So was there any investigation done by you to see maybe HR was mistaken or other people were mistaken by looking at any type of medical records associated with any of these patients --

A. Our job was not to perform an investigation. Our job was to give a hearing, we heard witness' testimony. And Dr. Papin had the opportunity to rebut that testimony. That was --

Q. Was there any follow-up after the hearing --

A. -- our role.

Q. -- regarding any of the things that Dr. Papin brought up that was in rebuttal to these allegations that were brought against him that he was a danger to patients and he was not rendering patient care?

A. Well we certainly discussed what was brought out at the hearing and --

Q. Did you ever follow --

A. -- we reviewed the documents.

Q. Did you ever follow-up with Dr. Papin to receive any of the text messages or anything that he brought up during the hearing to receive the actual copies of those before you rendered your decision to uphold his termination?

A. No. But as I said on the record in my conversation with Mr. Dillard, we didn't doubt that when Dr. Papin was reading those texts, that they were accurate. I certainly did not doubt them.

Q. Well you certainly, but can you speak for the other members on the panel who were part of the decision to uphold his termination whether it would may be --

A. It was discussed --

Q. -- potentially liked to have seen that information --

A. No. We -- we --

Q. -- I'm a visual person.

STENOGRAPHIC REPORTER: I cannot get both of you --

MR. WHITFIELD: Hey, guys, guys, y'all are talking over each other.

STENOGRAPHIC REPORTER: Exactly.

MR. SCHMITZ: Sorry about that. You're

right.

Q. (BY MR. SCHMITZ) Look, I'm a visual person, I like to see things. So I know you can speak for yourself, you didn't doubt it. But, you know, wouldn't it -- shouldn't it been part of his due process to if you're going to let him rebut what witnesses are saying about him, for him to provide you with the documentary evidence that he has possession of right there on his phone, before you would render a decision to terminate -- or uphold a decision to terminate his employment?

A. When we -- when we discussed that particular aspect of the hearing, we gave Dr. Papin the benefit of the doubt that the text that he was reading were accurate, we had no reason to doubt them. I would note, that in terms of our discussion of the entire course of what was brought forward to the hearing, the issue about the decubitus ulcer was a relatively small portion. This was many, many instances with a lot of data, of which the decubitus ulcer situation was only one.

Q. As an attorney, when you went through law school training and advocacy training, you were taught I'm assuming at Harvard that it is advantageous to you as in presenting a case on behalf of a client, that to present exhibits to a jury or present exhibits to a judge, which demonstratively show situations or reflect

facts that can otherwise, you know, visually be seen; correct?

A. Yes.

Q. And there was no avenue provided to Dr. Papin to provide any of those exhibits, which he believed exonerated him or at least mitigated against the circumstances of his termination; correct?

MR. WHITFIELD: Object to the form.

THE WITNESS: Well he had the opportunity, and his attorney was at the hearing.

Q. (BY MR. SCHMITZ) Right. But did anybody ever ask him of these things that, you know, at the hearing, did anyone ever ask him, okay, well submit those to me when you're done and we will take that into consideration before we render our decision?

A. I don't believe we specifically asked him that, we offered him the opportunity to present the evidence, so he certainly had the opportunity.

Q. But he wasn't there. He was just on the phone reading text messages from his phone, so you have no idea whether?

A. Well he was represented by an attorney who was in the room, that was his attorney, not an attorney for the medical center.

Q. And that attorney was not allowed to speak

though; correct?

A. That attorney spoke frequently during the hearing. He was not allowed to question the witnesses. He spoke many times during the hearing.

Q. We're going to go to the next exhibit.

A. Okay. Is this Notice Letter to Papin?

Q. Yes.

A. Okay.

Q. And was this the Notice Letter prior to the hearing that you conducted on Dr. Papin's termination that he would have received before that hearing took place?

A. I'm not sure I've seen this letter before. But it appears to be what you state it is. Can I have a minute to read over it?

Q. Yeah. Go ahead. Go ahead. Of course.

A. Okay.

Q. Okay. So this would have been at the bottom of page one: "The following notice is hereby provided concerning Mr. Papin's dismissal." And then there's a rendition of the facts of the case.

So he began his residency as a first-year intern, it says here on July 1, 2016; correct?

A. That's what it says.

Q. The first complaint occurred 28 days into his

residency. I guess he had some interactions with nurse practitioners where he was saying something, "I'm a surgeon. You're not my boss." He would not check in with them and would not be seen until it was time for evening rounds. Did you ever follow-up or see any documentation regarding these alleged interactions?

A. Well Dr. Earl spoke about these during the hearing. And there was -- I saw some of the e-mails, which I believe were part of the documents at the hearing.

Q. Did you ever see any documents regarding the fact that I believe the attending he was working with at this time, had told him that he could go -- and some of is conflict was about the fact that he was told that he could go to the operating -- the OR -- and observe things and the nurse practitioners were trying to tell him to do something else, which was in conflict of what the instructions he had received from his attending --

A. Actually, based on what I saw, it wasn't in conflict because if I recall correctly, the attending had said that when his -- that if his work was done, he could go. And based on the description of the conflict, the work wasn't done.

Q. On page two of four of this document, it looks like about one, two, three paragraph down. There's a

paragraph that says: "Dr. Earl responded to Dr. Berger, sharing that he, too, had been apprised of issues and would follow up with Dr. Papin." And then it states: "Dr. Earl met with Dr. Papin on numerous occasions and provided feedback and counseling regarding his persistent professionalism and honest issues."

Is there any -- are you aware of any documentation of any of these meetings by Dr. Earl that he allegedly had regarding Dr. Papin's professionalism issues prior to the meeting, which is referenced below, which actually was in writing December 20th, 2016?

A. Let me break that down. In terms of the individual sessions of feedback, kind of the monthly feedback, no, the informal feedback, no. What there was is there's the I believe it's November, there is documentation of the -- I believe it's called "the milestones." So the summative evaluation, there is documentation of that.

Q. The written evaluations that everybody receives; right?

A. Yes.

Q. Dr. Papin in those summative evaluations kind of received some okay reviews, some negative reviews during that -- during that part of time?

A. I would call that review the worst I've ever seen in my years in license. There are --

Q. He didn't get negative reviews from every physician that reviewed him?

A. No. The pos -- I mean the negatives are bad and the positives are pretty -- they're pretty just boilerplate things. But when you read through those and especially when you look at the summative evaluation, that's -- that's --

Q. What made them the worst that you had ever seen?

A. To have that many deficiencies in professionalism and honesty, is I've never seen that before. No, I haven't seen everybody's. But I was on the Clinical Competency Committee, which is the equivalent of a resident for review committee at the fellowship level at UMMC for the Pediatric Critical Care Fellows. I'm a member of the same committee for our fellows here in Rochester. And to have those deficiencies at that level. Once again, as we were talking about before, when we see resident efficiencies, they're usually in knowledge base or skills or the ability to get the work done. We don't really tend to say that that new res -- interns have poor skills because they're expected not to be -- they're not expected not to be great at doing procedures because they haven't learned them yet. But in terms of knowledge base, that's where we tend to see them or that work efficiency. That's not what his evaluations were remarking on. They were remarking on his interpersonal ability to work well with others, which was -- which was very very lowly rate -- low-rated.

Q. So after receiving those written reviews regarding his -- as you described them, poor interpersonal skills working with others, in November they were the worst that, in your opinion, the worst you had ever seen, are you aware of whether Dr. Earl met with him after that to put him on some type of remediation plan, so that he can improve on those interpersonal skills to specifically make him aware in writing that, you know, this person had this problem with you, maybe you should go speak to them and apologize and fix that issue, are you aware of any meetings like that that would have occurred prior to this --

A. Well I don't know --

Q. -- December 20th sit down and between in November to December 20th?

A. I don't know whether anything occurred between the two of them. And other than the summative evaluation, I have not seen any written plan.

Q. Would things like that, the interpersonal issues and not being able to work well with others, is that something -- that's something that can be fixed; right, that's not something that you -- that someone can't be a doctor for, there's lots of jerk doctors out there; right?

A. Can it not be fixed? I think for many people it can be fixed. I think that, you know, over the course of six months when you've had notice of it for at least five of those six months and it's an ongoing problem and it's getting worse over that period time, I'm thinking maybe it couldn't be fixed. I mean there was --

Q. He was a -- he was a first-year resident; correct, so this was his first working experience and job?

A. I have no idea -- well, no. Because I know he had work experience between medical school and residency because he had a year where he worked in a lab I believe. That was discussed at the hearing. I mean almost getting the -- the substance of these issues are not -- they're not small and they're not unique to medicine.

Q. So after that, it says Dr. Earl met with Dr. Papin again on the 20th of December in 2016. This

meeting was to address recurring issues of professionalism. Right. So up to this point, he allegedly had some issues with -- according to this -- the issues that were brought up to this prior to this. If you scroll up, there were issues specifically named up here. He had some issues with some nurses. He had a run in with the nurse practitioner. There was an issue about him not knowing about the coffee pot -- or bringing the drink into a patient's room. So those are issues that are listed there. So the meeting was -- I guess these issues had been cropping up, so there was a meeting on December 20th that he was put on notice about. And at this meeting, it states that Dr. Earl specifically addressed his unwillingness to help with tasks, which that's listed above this; correct, that happened in the beginning of his residency?

A. Yes. I mean that's what it says.

Q. Okay. And then there was Dr. Papin leaving during the hospital -- leaving the hospital during duty hours to exercise; correct?

A. That's what it says.

Q. And that issue was brought up specifically at his appeals hearing about him leaving to exercise; correct?

A. Yes.

Q. And Dr. Papin offered text messages showing that he had been approved to do that by his Chief resident to leave -- to leave -- one time he asked to leave and it was approved, and then the next time he asks to go for a run, the Chief resident in this case acted -- reacted very differently and did not approve him going. He was actually upset the fact that he asked?

A. That's all correct.

Q. I'm sorry. I was talking too. What was your answer?

A. I said that's correct.

Q. Okay.

A. That was specifically discussed at the hearing.

Q. And that was -- there were text messages that he was referencing at the hearing that you never sought to get regarding that incident to show that, you know, he was receiving mixed messages from his Chief resident regarding whether that was allowed or permissible or not; correct?

A. That is correct. But once, again, we took those what Dr. Papin was saying as accurate as to what happened when we had our discussions. This particular incident about the exercise, it really -- it really didn't weigh in the conversation based on what Dr. Papin -- I'm sorry -- conversation only, it didn't really weigh in on our deliberation based on what Dr. Papin said to the Board and him reading the text message. We found that that was -- that was a, you know, a reasonable explanation of his point of view in that matter.

Q. That was one of the critical deficiencies; however, listed in his summative reviews that his brought notice about on things he needed to improve about; correct?

A. It was a deficiency. I think that it's -- the episode is interesting. But, once again, we did not see it as a dereliction that he went for a run. We -- we -- we took him at his word for what he read to us, that he had that documentation, that that e-mail -- so we didn't feel a need to see it because we believed him. I think this was a misunderstanding. Although, I do question it, I mean it does show kind of a -- kind of a gap in the way things work. But it's one of those things that in this situation, it seemed like it was actually corrected. So it didn't really weigh in on our deliberations about whether his termination was just.

Q. What things did weigh in on it?

A. I think it was the interpersonal relationships with nurses, nurse practitioners, co-workers. It was the overall work ethic. Those -- those were the things. And there was a, you know, a tenor of kind of dishonesty and not, you know, just not being professional.

Q. Well and as you see here, the meeting, it's listed as of December 20th, he had not had any issues at least that Dr. Earl brought to his attention regarding dishonesty up to that point; correct?

A. I don't know off the top of my head. I'd have to look back at the summative evaluation.

Q. Well just looking right here, this Notice Document is not letting him know that there was any issues with his candor prior to December 20th; correct?

A. No. I disagree with that. In the paragraph before that, Dr. Earl met with Dr. Papin on numerous occasions and provided feedback and counseling regarding his persistent professionals and honesty issues.

Q. Okay. Where in this document, this Notice Document that he received prior to the hearing that you conducted does it say he had issues with candor prior to December 20th?

A. Candor and honesty are the same -- are synonyms.

Q. Right.

A. It says it in that sentence right above Dr.

Earl met with Joe Papin again on December 20th. It says it in the sentence right before that.

Q. Okay. But honesty issues, what honesty did you ever -- are you aware whether Dr. Papin was specifically put on notice other than just the vague one mention of these honesty issues about what these issues were, so he could address them prior to the --

A. I have -- I have no idea about the specific conversations, or I should say I have no specific ideas about what light to this letter. I wasn't involved in that process.

Q. Okay. Then it says, "After this meeting, Dr. Papin's performance did not improve and patient safety issues developed concerning Dr. Papin's behavior." It says, "Renee Greene, Senior Education Administrator, received e-mails concerning Dr. Papin's performance."

Do you know whether Dr. Earl or Ms. Greene solicited those e-mails or whether they just came out of the blue?

A. I have no idea.

Q. There's an incident reference on January 3rd where long story short, it basically says that he was suppose to admit a patient into the ICU and call down. And whether the ICU had responded back that the person just never note -- ICU I guess was never notified and

just showed up there. And Dr. Papin at the hearing, did you recall what he testified in response to rebut this allegation?

A. If I recall correctly, my -- it's hard because I've read the transcript, and I also read over the transcript of the HR conversation about this incident. But that he called someone but didn't remember who it was, and that it might have been a nurse.

Q. Okay. Is that possible, I mean you work in the ICU, it's probably very busy, that's possible he could have spoken to somebody in passing that was busy themselves?

A. ICU admissions aren't something --

MR. WHITFIELD: Object to the form.

THE WITNESS: Oh, sorry, Tommy.

MR. WHITFIELD: Object to the form. You can answer.

THE WITNESS: ICU admissions aren't something that are done informally. These are the sickest patients. They by definition are gravely ill. So we have -- we have direct conversations with people about admissions. So as an attending, I receive a call from, typically, they come from, in my case, either the emergency department or from the -- from the operating room. I receive a phone call from the attending emergency physician who identifies themself. They, you know, make sure they're talking to me, and we have a conversation. For patients that come from the operating room, I get two phones calls. I get one from the attending surgeon, as well as one from the attending anesthesiologist. Once again, they're calling me, they know who I am, and they're giving me a structured handoff, so that I am prepared to take care of that patient as soon as they get there because sometimes these patients are unstable upon arrival to the IC Unit.

When our residents communicate with one another, they do the same thing at their level. So the resident calls and talks to the resident and has a handoff. The nursing handoff is completely different from the physician handoff. The nurses also have handoff, they call it "calling report." But their handoff is different. Those aren't things you mistake for one another. Certainly, not someone -- and it's not something someone should have -- it's not an error of somebody who had been in the ICU for more than a few days would have made it, if it happened at all.

So this is an extremely important issue. This -- this missed handoff is an extremely important issue.

Q. (BY MR. SCHMITZ) Again, I'm sure that this happens from time to time, in the things that do happen,

it's not unheard of that this happens?

A. When it does, we make a big deal out of it. It's a big deal.

Q. Is it an immediately separable offense on its own right?

A. Based on -- based on one event, probably not. But it's a big deal.

Q. Next there's talking about Dr. William Crews, PGY3 Surgical Resident. I believe he was only a medical student, at that time, were you aware of that, he was not, in fact, a resident?

A. Yes, I was aware of -- I think that's -- I think they mean MS3, not PGY3, that's a typo.

Q. Okay. He states: "Dr. Crews reported that Dr. Papin always seemed to show up just before rounds without actually having seen any of the patients and then would lie to residents about what he had done. When caught doing something wrong, he would blame a medical student for his own errors. Dr. Crews also talked to Dr. Mahoney, Surgery House Officer, about Dr. Papin's behavior."

Was there anything done in terms of verifying whether Dr. Papin was doing his rounds or not because certainly someone like Dr. Crews would not always be with Dr. Papin to do pre-rounds in the morning and